STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING _____ B. WING _____	C 04/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	**1420 E DOUGLAS RD MISHAWAKA, IN 46545**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint #IN00145730. This visit was in conjunction with the Investigation of Complaint #IN00146093. Complaint #IN00145730- Substantiated. No deficiencies related to the allegations are cited. Survey Dates: March 27,28,29,31, and April 1 & 2, 2014. Facility Number: 012329 Provider Number: 155784 AIM Number: 201002500 Survey Team: Julie Baumgartner, RN, TC Shauna Carlson, RN Sharon Ewing, RN (March 31 and April 1 & 2, 2014) Pamela Williams, RN (March 31 and April 1 & 2, 2014) Census Bed Type: SNF: 27 SNF/NF: 52 Total: 79 Census by Payor Type: Medicare: 27 Medicaid: 39 Other: 13 Total: 79 Michiana Health and Rehabilitation Center was	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155784	A. BUILDING _____ B. WING _____	C 04/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MICHIANA HEALTH AND REHABILITATION CENTER	**1420 E DOUGLAS RD MISHAWAKA, IN 46545**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2, in regard to the Recertification and State Licensure Survey and the Investigation of Complaint IN#00145730. Quality Review completed on April 7, 2014, by Brenda Meredith, R.N.	F 000		